	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAIN	OF CORRECTION	15G442	A. BUIL		00	11/13/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			/ING LN		
		LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
W000000	REGULATORT OF	CESC IDENTIFY TING INFORMATION)		IAG			DATE
	This visit was fo	or a pre-determined full	W00	00000			
		nd state licensure survey.					
		•					
	Dates of Survey	: November 12 and 13,					
	2014.						
	Facility Number	r: 000956					
	Provider Numbe						
	AIMS Number:	100244760					
	Surveyor: Dotty	y Walton, QIDP.					
		eficiencies reflect state					
	_	rdance with 460 IAC 9.					
		completed 11/20/14 by					
	Ruth Shackelfor	rd, QIDP.					
W000125	483.420(a)(3)						
		F CLIENTS RIGHTS					
		ensure the rights of all					
		e, the facility must allow dividual clients to exercise					
	_	ents of the facility, and as					
	citizens of the Uni	ited States, including the					
		aints, and the right to due					
	process.		11/04	00125			12/12/2014
		vation, record review and	W 00	00125	W125: 483.420(a)(3)		12/13/2014
		of 4 sampled clients (#1,			PROTECTION OF CLIENT	S	
	#2,				RIGHTS	-	
					l		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED	
		15G442		LDING		11/13/2014	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	2			VING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	JEFFERSONVILLE, IN 47130				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		facility failed to ensure					
		eir surrogates consented					
	to sharps (knive	s) being locked.			The facility must ensure the	,	
					rights of all clients. Therefore		
	Findings include:				the facility must allow and		
					encourage individual clients	s to	
	Observations we	Observations were conducted at the			exercise their rights as clien		
	facility from 4:0	0 PM until 6:00 PM on			of the facility, and as citizen		
	11/12/14. At 4:1	5 PM, staff #5 came into			the United States, including		
	the medication/o	office room, and accessed			right to file complaints, and	the	
	a metal box kept in a locked filing cabinet. She retrieved a sharp knife for				right		
		as preparing the evening			to due process.		
		ndicated (11/12/14 at 4:15					
		nives were kept locked in					
		client #5's behavior.			Corrective Action: (specific):	Гће	
	the office due to	enent #3 s behavior.			Residential Manager and QIDP		
	Client #1's recor	d was reviewed on			be in-serviced on ensuring the IS		
		5 AM. The record			contains all rights restrictions an		
					proper notification of the individ		
		#1 was her own guardian			guardians/HCR/Advocate as we HRC approvals are obtained bef		
		as her advocate. The			implementation of a rights restri		
		dicated an ISP/Individual			occurs. The Clinical Supervisor		
	* *	ted 10/18/13. The ISP			be in-serviced on ensuring all rig		
		ention of or consent to			restrictions are in place and revi	ewed	
	-	s locked at the facility by			by the individual,	.,	
	client #1 or her a	advocate.			guardians/HCR/Advocate as we		
					HRC approvals are obtained price implementation of the rights	UI IO	
	Client #2's recor	d was reviewed on			restriction.		
	11/13/14 at 11:0	5 AM. The record					
	indicated client	#2 had an ISP dated					
	9/26/14. The rec	ord review indicated the					
	client had a Hea				How others will be identified:	11	
	Representative/I	HCR to assist in decision			(Systemic): The QIDP will revi the clients Individual Support Pl		
	-	ord review indicated no			include any and all rights restric		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G442	B. WIN			11/13/2014
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	t.		402 EW	/ING LN	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	need for or conse	ent from client #2 or her			notify the individual,	
	HCR for locking	g sharps.			guardians/HCR/Advocate and see	
		1			HRC approvals for all restrictions	
	Client #3's record was reviewed on 11/13/14 at 11:18 AM. The record				the home prior to implantation of	
					rights restriction for all individual	
		#3's father served as her			The Clinical Supervisor will revie the ISP's monthly to ensure all	zw
					proper notifications and HRC	
	~ ~	The review indicated an			approval occurs for any rights	
		Client #3's ISP did not			restrictions. The Bill of Rights an	d
		ion about locking sharps.			the Grievance Policy will be	
	Client #3's guard	lian had not consented to			reviewed and renewed with each	
	the locking of the	e sharps.			client to ensure clients are aware	of
					the policy and the procedure for	
	Client #4's recor	d was reviewed on			filing complaints and their right for due process.	or
	11/13/14 at 10:3	5 AM. The record			due process.	
	indicated client #	#4 had an ISP dated				
		ord indicated client #4's				
		s her legal guardian.			Measures to be put in place: The	
	Client #4's ISP d				Residential Manager and QIDP w	
					be in-serviced on ensuring the ISI	
		ut locking sharps. Client			contains all rights restrictions and	
	~	d not consented to the			proper notification of the individuguardians/HCR/Advocate as well	
	locking of the sh	arps.			HRC approvals are obtained befo	
					implementation of rights restriction	
		Administrator #1 on			occurs. The Program Manager wi	
		PM indicated no further			be in-serviced on ensuring all rig	hts
	information rega	arding the missing			restrictions are in place and	
	consents for lock	king sharps at the facility.			reviewed by the individual,	
					guardians/HCR/Advocate as well	
	9-3-2(a)				HRC approvals are obtained prior implementation of the rights	110
					restriction.	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/13/2014
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP CODE VING LN RSONVILLE, IN 47130	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	N (X5) BE COMPLETION DATE
				Monitoring of Corrective Act The QIDP will revise all the cli Individual Support Plan to incl the rights restriction, notify the individual, guardians/HCR/Ad and seek HRC approvals for al restrictions in the home prior to implantation of the rights restri for all individuals. The Clinica Supervisor will review the ISP monthly to ensure all proper notifications and HRC approva occurs for any rights restriction Bill of Rights and the Grievand Policy will be reviewed and ret with each client to ensure clien aware of the policy and the procedure for filing complaints their right for due process.	ients ude e vocate 1 o iction 1 's al ns. The ce newed ats are
W000149	The facility must of written policies and mistreatment, neg Based on record 3 of 10 investiga 4 of 4 sampled of #4), and 4 additional facility of the facility	ENT OF CLIENTS develop and implement id procedures that prohibit plect or abuse of the client. review and interview for ations reviewed, affecting clients (#1, #2, #3, and onal clients (#5, #6, #7, lity failed to ensure their	W000149	Completion date: 12-13-14 W 149: 483.420(d)(1) STAI TREATMENT OF CLIEN	

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Event ID:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DING	00	COMPLETED
		15G442	A. BUII B. WIN	LDING		11/13/2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹				
DEC CAL		LTERNATIVES SE IN			/ING LN RSONVILLE, IN 47130	
KES CAI	RE COMMUNITY A	LIERNATIVES SE IN		JEFFER	RSONVILLE, IN 47 130	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	policies prohibit	ing abuse and			The facility must develop and	
	exploitation wer	e implemented. The			implement written policies ar	nd
	facility failed to	ensure their			procedures that prohibit	
	investigations w	ere completed and the			mistreatment, neglect or abu	se
	1	to the administrator in			of the clients.	
	_	acility failed to ensure				
	1	corrective action (reimbursements of clients' funds) was completed.				
					Corrective Action: (Specific)	\ n
	chents funds) w				investigation was completed	MII .
	Findings include:				regarding the missing money.	
					Clinical Supervisors will be	
					in-serviced on the initiating	
	Facility investig	ations were reviewed on			investigations and having them	
	11/12/14 at 2:00	PM and on 11/13/14 at			completed within 5 business days	
	9:35 AM and inc	dicated the following:			and the final investigation will be	
		2			sent to the Business Office Mana	-
	1 On 10/01/14	an investigation was			and all funds will be reimbursed to	
		ds to staff #8 being			the RFMS account. All staff wil	
		•			in-serviced on the Abuse Neglect Exploitation Policy and Procedur	
	•	ng responsible for			and client finances. A safe was	CS
	_	ats #1, #2, #3, #4, #5, #6,			purchased for the home to secure	all
		Investigation was			client finances.	
	completed on 10	0/10/14 and could not be				
	substantiated.					
	2. On 9/29/14 ar	n investigation was			How others will be identified:	
		ds to staff #7 being			(Systemic) The Program Manage	r
		to client #1. The			will follow up with the Clinical Supervisor at least weekly to ensu	ura
	1	as completed on 10/13/14			that all incidents that require and	
	_	r staff #2 and was			investigation are initiated and	
	1 -	i Stail #2 allu was			completed within 5 business days	s.
	substantiated.				The Program Manager will ensur	
					the Clinical Supervisor submits a	
	3. On 7/05/14 it was reported that clients				finalized investigations to the	
	#5 and #8 were 1	missing personal money			Business Office Manager to ensur	
	which had been	kept at the facility. The			funds are reimbursed to the client	
		is not completed until			All investigations will be provide	d to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
			(X2) M	JLTIPLE CC		î ´	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
		15G442	B. WIN	G		11/13	/2014
NAME OF I	PROVIDER OR SUPPLIEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SULLEIE	X.		402 EW	VING LN		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	BROWINEBIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	8/26/14.				the Executive Director upon		
	The missing mo	ney was substantiated;			completion for review. The		
	client #5 lost \$52.00 and client #8 lost \$43.00. Review of the clients' resident funds				Residential Manager will comple		
					review of all client finances week	-	
					to ensure that all funds are accou		
					for. The Clinical Supervisor will review client finances at least one		
	management sys	· ·			time monthly to ensure the client		
		/3/14 through 11/12/14			funds are accounted for.		
	indicated they h	ad not been reimbursed			runds are accounted for.		
	the missing mor	ney.			Measures to be put in place:		
					Corrective Action: (Specific)	A n	
	Interview with a	accounting staff #1 on			investigation was completed		
		PM indicated the money			regarding the missing money.		
		ted but had not been			Clinical Supervisors will be		
	^				in-serviced on the initiating		
	reimbursed to cl	ients #5 or #8.			investigations and having them		
					completed within 5 business days		
	Interview with A	Administrator #1 on			and the final investigation will be		
	11/13/14 at 2:30	PM indicated the			sent to the Business Office Mana	-	
	investigations w	ere not timely; they were			and all funds will be reimbursed the RFMS account. All staff wil		
	_	within 5 working days of			in-serviced on the Abuse Neglect		
	knowledge of th				Exploitation Policy and Procedur		
	Knowledge of th	e meident.			and client finances. A safe was	CS	
					purchased for the home to secure	all	
		glect/Exploitation Policy			client finances.		
		component of the					
	agency's 08/01/0	07 Operational Policy and					
	Procedure Manu	nal (revised 07/02/2012)					
	was reviewed or	n 11/12/2014 at 3:00 PM.			Monitoring of Corrective Action		
		cated the agency			The Program Manager will follow	~	
		e and neglect of clients.			with the Clinical Supervisor at le		
	^	were as follows:			weekly to ensure that all incident		
	The definitions	were as fullows.			that require and investigation are		
					initiated and completed within 5 business days. The Program Man	ager	
	"B. AbuseVe				will ensure the Clinical Supervisor		
	1. The act of ins	sulting or profane			submits all finalized investigation		
	language or gest	tures directed toward an			the Business Office Manager to	-5 05	
	individual that s	ubject him or her to			ensure funds are reimbursed to the	ie	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G442	B. WING		11/13/2014
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP CODE WING LN RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	humiliation or d 2. Coarse, loud that is perceived offending or thr E. AbuseExpl Definition: 1. An act that d	egradation. tone, or with language I by an individual as eatening		clients. All investigations will be provided to the Executive Director upon completion for review. The Residential Manager will comple review of all client finances week to ensure that all funds are account for. The Clinical Supervisor will review client finances at least one time monthly to ensure the client funds are accounted for.	or e ete a kly nted
W000156	The results of all reported to the acrepresentative or accordance with sworking days of the Based on record 3 of 10 investigated 4 of 4 sampled 6 #4), and 4 additional reported for the sample of the	ENT OF CLIENTS investigations must be Iministrator or designated to other officials in State law within five ne incident. I review and interview for ations reviewed, affecting clients (#1, #2, #3, and ional clients (#5, #6, #7, lity failed to ensure the	W000156	W 156 483.420(d)(4) STAFF TREATMENT OF CLIENT The results of all investigation must be reported to the	S
	investigations w	rere completed and the to the administrator in		administrator or designated representative or to other officials in accordance with State law	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 00 COMPLETED . BUILDING 15G442 11/13/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 402 EWING LN RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG Findings include: within five working days of the incident. Facility investigations were reviewed on 11/12/14 at 2:00 PM and on 11/13/14 at Corrective Action: (Specific): The 9:35 AM and indicated the following: Clinical Supervisor will be in-serviced on reporting all incidents of abuse/neglect per BDDS policy 1. On 10/01/14 an investigation was and procedure as well as all initiated in regards to staff #8 being allegations of abuse/neglect are asleep while being responsible for investigated and completed within monitoring clients #1, #2, #3, #4, #5, #6, the 5 working days. #7, and #8. The Investigation was How others will be identified: completed on 10/10/14 and could not be (Systemic): The Program Manager substantiated. will review incident reports and investigations at least weekly to 2. On 9/29/14 an investigation was ensure that all reports required are filed with BDDS and that all initiated in regards to staff #7 being investigations are completed within 5 verbally abusive to client #1. The working days per policy and Investigation was completed on 10/13/14 procedure. All investigations will be by Administrator staff #2 and was provided to the Executive Director substantiated upon completion for review. Measures to be put in place: The 3. On 7/05/14 it was reported that clients Clinical Supervisor will be #5 and #8 were missing personal money in-serviced on reporting all incidents which had been kept at the facility. The of abuse/neglect per BDDS policy Investigation was not completed until and procedure as well as all allegations of abuse/neglect are 8/26/14. investigated and completed within The missing money was substantiated; the 5 working days. client #5 lost \$52.00 and client #8 lost \$43.00. **Monitoring of Corrective Action:** The Program Manager will review incident reports and investigations at Interview with Administrator #1 on least weekly to ensure that all reports

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11/13/14 at 2:30 PM indicated the

investigations were not timely; they were

to be completed within 5 working days of

Event ID:

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required are filed with BDDS and

that all investigations are completed

within 5 working days per policy and

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G442	A. BUII	A. BUILDING 00 COMPLETED 11/13/2014			
		130442	B. WIN			11/13/	2014
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG	knowledge of the	LSC IDENTIFYING INFORMATION)		TAG	procedure. All investigations will		DATE
	knowledge of the	e incident.			provided to the Executive Director		
	9-3-2(a)				upon completion for review.		
	9-3-2(a)						
					Completion date: 12-13-14		
W000157	483.420(d)(4)						
	STAFF TREATME	ENT OF CLIENTS					
	If the alleged violation is verified, appropriate						
	corrective action n		11/0	00157	MAET: 402 420(4)(4) STAFE		12/12/2014
		review and interview for	WU	00157	W157: 483.420(d)(4) STAFF TREATMENT OF CLIENTS	f	12/13/2014
	_	tions reviewed, affecting			the alleged violation is verific		
		nts (#5 and #8), the			appropriate corrective action		
	_	ensure corrective action			must be taken. Corrective		
	`	s of clients' funds) was			Action: (Specific) An investigation was completed		
	completed.				regarding the missing money.		
	Findings in deal				Clinical Supervisors will be		
	Findings include) <u>.</u>			in-serviced on the initiating		
	Eggilitz immedia	otiona vyono noviovyod on			investigations and having then completed within 5 business d		
		ations were reviewed on			and the final investigation will		
		PM and on 11/13/14 at			sent to the Business Office		
	7.33 AIVI and inc	licated the following:			Manager and all funds will be		
	On 7/05/14 it wa	as reported that clients #5			reimbursed to the RFMS acco		
		sing personal money			Abuse Neglect Exploitation Po		
		kept at the facility. The			and Procedures and client		
		s not completed until			finances. A safe was purchas		
	8/26/14.	s not completed until			for the home to secure all clier finances. How others will I		
		ney was substantiated;			identified: (Systemic) The	Je	
	_	2.00 and client #8 lost			Program Manager will follow u	р	
	\$43.00.	2.00 and Cheff #0 108t			with the Clinical Supervisor at		
	•	ients' resident funds			least weekly to ensure that all		
	Keview of the cl	iems resident lunds			incidents that require and		

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Event ID:

BZXY11 Facility ID: 000956

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVE	EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLETED	
		15G442	B. WIN			11/13/2014	
			p. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			/ING LN		
RES CAR	RE COMMUNITY A	ALTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	IPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	П	DATE
	management sy	stem accounting			investigation are initiated and		
	statements for 3	3/3/14 through 11/12/14			completed within 5 business		
	indicated they h	nad not been reimbursed			days. The Program Manager v	/III	
	the missing mo				ensure the Clinical Supervisor submits all finalized investigations		
	the missing mo	ncy.			to the Business Office Manage		
		20.44			to ensure funds are reimburse		
		accounting staff #1 on			the clients. All investigations w		
	11/13/14 at 1:30	0 PM indicated the money			be provided to the Executive		
	had been reques	sted but had not been			Director upon completion for		
	reimbursed to c	lients #5 or #8.			review. The Residential Mana	ger	
					will complete a review of all cli	ent	
	0.2.2(a)				finances weekly to ensure that	all	
	9-3-2(a)				funds are accounted for. The		
					Clinical Supervisor will review		
					client finances at least one tim		
					monthly to ensure the client fu		
					are accounted for. Measures	to	
					be put in place: Corrective		
					Action: (Specific) An		
					investigation was completed		
					regarding the missing money. Clinical Supervisors will be		
					in-serviced on the initiating		
					investigations and having then	,	
					completed within 5 business d		
					and the final investigation will	-	
					sent to the Business Office		
					Manager and all funds will be		
					reimbursed to the RFMS acco	unt.	
					All staff will be in-serviced on	the	
					Abuse Neglect Exploitation Po	licy	
					and Procedures and client	.	
					finances. A safe was purchas		
					for the home to secure all clier	ıı	
					finances. Monitoring of	,	
					Corrective Action: The Programman Manager will follow up with the		
					Clinical Supervisor at least we		
					to ensure that all incidents tha	-	
					require and investigation are	·	
					initiated and completed within	₅	
	1		I		1	-	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15G442	B. WING		11/13/2014
	RE COMMUNITY AL	TERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP CODE VING LN RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
W000159	PROFESSIONAL Each client's active be integrated, coo a qualified mental Based on record the facility failed clients (#1, #2, # clients' active tre coordinated and facility's Qualified Disabilities Profe facility failed to summaries were failed to ensure a	FAL RETARDATION The treatment program must redinated and monitored by retardation professional. The review and interview, and for 4 of 4 sampled and for 4 of 4 sampled and for the eatment programs were atment programs were monitored by the ead Intellectual essional (QIDP). The ensure client monthly done by a QIDP and all Individual Support at least annually.	W000159	business days. The Program Manager will ensure the Clini Supervisor submits all finalize investigations to the Business Office Manager to ensure fun are reimbursed to the clients. investigations will be provided the Executive Director upon completion for review. The Residential Manager will complete a review of all client finances weekly to ensure the funds are accounted for. The Clinical Supervisor will review client finances at least one time monthly to ensure the client fare accounted for. Corrective Action Date: 12-13-14 W 159 483.430(a) QUALIFI MENTAL RETARDATION PROFESSIONAL Each client's active treatme program must be integrated coordinated and monitored a qualified mental retardation professional.	cal ed s ids All d to t at all e v me unds 12/13/2014 IED nt l, by

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G442	A. BUII B. WIN			11/13/	2014
			F. ""		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	: :			Corrective Action: (Specific): T		
	_				QIDP will be in-serviced on ensu		
	Record review for	or client #1 was done on			the Individual Support Plans (ISP		
	11/13/14 at 10:0				and Behavior (BSP) Support Plan	ıs	
					are updated at least annually and	,	
		Client #1's record contained program reviews but they were not by a Qualified			revised as changes occur through		
	_				the year. Client #1's ISP and BSF		
	Intellectual Disa				will be updated due to its expirati occurring in the month of Octobe		
	Professional/QII	OP. The client's			2014. Client #2's ISP will be revi		
	ISP/Individual S	upport Plan was dated			by the QIDP and will include the		
	10/18/13. The IS	P had not been done			team to formulate the plan. Client	t	
		degreed manager was			#4's ISP and BSP will be revised		
	_	or instead of a QIDP.			include the QIDP. Client #1, 2, 3		
		~			4's monthly summaries will be		
	_	s of the client's ISP had			completed by the QIDP as well as		
		by direct support staff			clients in the home. The QIDP w		
	instead of a QID	Р.			be in-serviced on ensuring annual		
					Individual Support (ISP) meeting		
	Record review for	or client #2 was done on			occur timely and the BSP's, ISP's		
	11/13/14 at 11:0	5 AM. Client #2's record			and goal development takes place		
		DP program reviews			appropriate consents, signatures a		
	,	red 9/27/14. The review			HRC approvals are obtained for client ISP's and BSP's and a more		
					review of all documents occurs.	-	
	-	OP had been involved in			QIDP will be in-serviced and	1110	
		of the ISP. A house			responsible for ensure all staff are	•	
	_	was on the documents as			trained on the plans and are		
	the author (non-	degreed).			implementing them. The Clinical		
					Supervisor will be in-serviced on		
	Record review for	or client #3 was done on			supervising the activities of the		
		8 AM. Client #3's record			QIDP to ensure that annual ISP, I		
		DP program reviews			development and revisions, conse	ents,	
	since the ISP dat	1 0			signatures, HRC approvals and		
	since the ISP dat	.cu 2/0//14.			monthly summaries are occurring	<u>.</u>	
					The Clinical Supervisor will be	.1	
		or client #4 was done on			in-serviced on ensuring the month	-	
	11/13/14 at 10:3	5 AM. Client #4's record			summaries are in the home and be completed and the QIDP is	ring	
	contained no QII	DP program reviews			reviewing and signing the monthl	v	
	,	ted 9/16/14. The review			summaries.	'y	
			L		Summing too.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		15G442	B. WIN			11/13/2	2014
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .		402 EW			
	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
		vior Support Plan/BSP					
	•	here was no signature					
		a QIDP or Behavior			How others will be identified:		
	Specialist had be	een involved in the			(Systemic) The QIDP will be		
	formulation of th	ne ISP or BSP.			involved in writing and revising t	he	
					Individual Support Plans and		
	Interview with A	Administrator #1 on			Behavior Support Plans for all	.	
		PM failed to indicate			individuals in the home to as well		
		or Behavior Specialist			assuring all necessary revisions to plans occurs throughout the year.		
		and been monitoring the			The QIDP will be responsible for		
		•			assuring the monthly summaries		
	clients' programs	5.			been completed and signed for ea		
	0.2.2()				client in the home. In addition the		
	9-3-3(a)				QIDP will conduct annual Individual	dual	
					Support Plan meeting for all clien		
					and provide a signature assuring a	a	
					QIDP was involved in the	_	
					formulation of the plan. The QID		
					will develop goals for each client provide staff training on all	,	
					documents, and ensure the data		
					collection is occurring as well as	goal	
					implementation is occurring on a	~	
					daily basis. The Clinical Superv	isor	
					will review the Monthly Summar		
					to ensure the QIDP is reviewing a	and	
					signing. In addition the Clinical		
					Supervisor will ensure the QIDP		
					completing annual ISP's, revising BSP's and completing staff traini		
					as necessary.	''g	
					Measures to be put in place: The	e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. BUILDING 00		COMPLETED	
15G442		B. WING		11/13/2014	
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	8		VING LN	
RES CARE COMMUNITY ALTERNATIVES SE IN				RSONVILLE, IN 47130	
				1	(775)
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	COMPLETION COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	· ·	DATE
				QIDP will be in-serviced on en	_
				the Individual Support Plans (IS	
				and Behavior (BSP) Support Pl	
				are updated at least annually an	
				revised as changes occur through	
				the year. Client #1's ISP and B	
				will be updated due to its expira	
				occurring in the month of Octob 2014. Client #2's ISP will be re	
				by the QIDP and will include the	
				team to formulate the plan. Clie	
				#4's ISP and BSP will be revise	
				include the QIDP. Client #1, 2	
				4's monthly summaries will be	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
				completed by the QIDP as well	as all
				clients in the home. The QIDP	
				be in-serviced on ensuring annu	
				Individual Support (ISP) meeting	
				occur timely and the BSP's, ISI	P's
				and goal development takes pla	ice,
				appropriate consents, signature	s and
				HRC approvals are obtained f	
				client ISP's and BSP's and a m	- I
				review of all documents occurs	. The
				QIDP will be in-serviced and	
				responsible for ensure all staff	are
				trained on the plans and are	,
				implementing them. The Clinic	
				Supervisor will be in-serviced of	
				supervising the activities of the	
				QIDP to ensure that annual ISP development and revisions, cor	
				signatures, HRC approvals and	ischis,
				monthly summaries are occurri	nα
				The Clinical Supervisor will be	_
				in-serviced on ensuring the mor	
				summaries are in the home and	=
				completed and the QIDP is	<u></u>
				reviewing and signing the mont	thly
				summaries.	<i>y</i>
			I		1

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G442		A. BUILDING O		(X3) DATE SURVEY COMPLETED 11/13/2014			
150442		B. WING		11/13/2014			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID SUMMARY STATEMENT OF DEFICIENCE PREFIX (EACH DEFICIENCY MUST BE PRECEDED IN TAG REGULATORY OR LSC IDENTIFYING INFOR		CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION (X5) HOULD BE COMPLETION APPROPRIATE DATE		
				Monitoring of Correction The QIDP will be involved and revising the Individual Plans and Behavior Supplier all individuals in the well as assuring all necessary in the plans occurrence of throughout the year. The best responsible for assuring monthly summaries have completed and signed for in the home. In addition will conduct annual Indiscupport Plan meeting for and provide a signature at QIDP was involved in the formulation of the plan. Will develop goals for easy provide staff training on documents, and ensure the collection is occurring as implementation is occurrenced as implementation is occurrenced as impl	red in writing all Support port Plans home to as ssary curs e QIDP will ng the e been or each client the QIDP vidual r all clients assuring a ne The QIDP ach client, all he data s well as goal ring on a all Supervisor Summaries viewing and Clinical ne QIDP is s, revising taff training		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. BUILDING 00			COMPLETED			
15G442		B. WING 11/13/2			11/13/2014			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN				
RES CAF	RE COMMUNITY AL	_TERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY	DATE		
W000362	regimen of each of Based on record the facility failed clients, (clients # provide evidence	input from the am must review the drug lient at least quarterly. review and interview, I for 4 of 4 sampled \$1, #2, #3 and #4), to the pharmacist	W0	00362	W 362 483.460(j)(1) DRUG REGIMEN REVIEW	12/13/2014		
		edications on a quarterly	rterly					
	basis. Findings include Client #1's record	: d was reviewed on			A pharmacist with input from the interdisciplinary team more review the drug regimen of each client at least quarterly	ust		
	indicated client # medications for I and supplements indicated the pha client #1's medic 7/28/14. There w indicate a pharm #1's medications	5 AM. The record ‡1 received daily her heart, hypertension . The record review harmacist had reviewed ations on 04/24/14 and vas no evidence to acist's review of client for potential side effects ons every quarter for the			Corrective Action: (Specific): To consulting pharmacy has been contacted to complete pharmacy reviews of current medication regimen on client's #1,2,3 and 4 a well as all other consumers in the home. The nurse and the resident manager will be in-serviced on the ensuring that pharmacy reviews a completed at least quarterly for all clients.	as tial ne nre		
	11/13/14 at 11:0: indicated client # Depo Provera sh record review increviewed client #	d was reviewed on 5 AM. The record ‡2 received quarterly ots for birth control. The dicated the pharmacist's ‡2's medication on ‡/14 during the calendar			How others will be identified: (Systemic): The nurse and the residential manager will review a clients' pharmacy reviews of medication regimens to ensure the there is a quarterly review in place. The nurse will review all client pharmacy medication reviews at 1	at ee.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, DITT DDIG 00		COMPLETED		
15G442		A. BUILDING B. WING 11/13/20		2014			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1			
DEC CAI		ALTERNATIVES SE IN			VING LN RSONVILLE, IN 47130		
RES CAI	RE COMMUNITY F	ALTERNATIVES SE IN		JEFFER	RSONVILLE, IN 47 130		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	year of 2014. The	here was no evidence to			monthly to ensure that medication		
	indicate a pharm	nacist's review of client			reviews are being completed timely		
	#2's medication	s for potential side effects			by the pharmacist. The Nursing	-	
		ions every quarter during			Manger will review client record least quarterly to ensure that all	is at	
	2014.	tens every quarter auring			clients have a review of medicat.	ion	
	2014.				regimen completed by the pharm		
	G1:	1			at least quarterly.	ideist	
		rd was reviewed on			at reast quarterry.		
		18 AM. The record					
	indicated client	#3 received daily					
	medications for	behavior management,			Measures to be put in place: T	he	
	allergies and su	pplements. The record			consulting pharmacy has been		
	review indicated no evidence of any				contacted to complete pharmacy		
		•			reviews of current medication		
	pharmacist's review of client #3's medications. There was no evidence to				regimen on client's #1,2,3 and 4		
					well as all other consumers in the		
	1	nacist's review of client			home. The nurse and the resider		
		s for potential side effects			manager will be in-serviced on the ensuring that pharmacy reviews		
	or drug interact	ions.			completed at least quarterly for a		
					clients.		
	Client #4's reco	rd was reviewed on					
	11/13/14 at 10:3	35 AM. The record					
	indicated client #4 received daily medications for behavior management,						
					Monitoring of Corrective Actio	n:	
	1				The nurse and the residential		
	allergies, and supplements. The record review indicated the pharmacist				manager will review all clients'		
					pharmacy reviews of medication		
		#4's medications on			regimens to ensure that there is a		
	4/24/14 and 7/2	8/14 for the calendar year			quarterly review in place. The n will review all client pharmacy	urse	
	of 2014. There	was no more evidence to			medication reviews at least mon	thly	
	indicate a pharm	nacist's review of client			to ensure that medication review	-	
	_	s for potential side effects			being completed timely by the		
	or drug interact	-			pharmacist. The Nursing Mange	er	
					will review client records at leas		
	The Administra	tor (stoff #1) was			quarterly to ensure that all client	s	
		tor (staff #1) was			have a review of medication regi	imen	
		11/13/14 at 2:50 PM. She			completed by the pharmacist at l	east	
indicated there was nothing signed or					quarterly.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED			
15G442			B. WIN	B. WING			11/13/2014		
NAME OF P	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN						
RES CARE COMMUNITY ALTERNATIVES SE IN				JEFFERSONVILLE, IN 47130					
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE		
	dated by a pharmacist to indicate a review of clients #1, #2, #3 and #4's medications every quarter for the								
calendar year of 2014 by a pharmacist for potential side effects or drug interactions.									
	9-3-6(a)				Completion date: 12-13-14				

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